Washington State
Department of Social
& Health Services

Report to the Legislature

Report on Elimination of Licensed Nursing Facilities and Beds

Sec. 8, c 366, Laws of 2011

August 31, 2011

Department of Social & Health Services
Aging and Disability Services Administration
Management Services Division/Office of Rates Management
P. O. Box 45600
Olympia, WA 98504-5600
(360) 725-2469
Fax: (360) 725-2641

Contents

Executive Summary

The statute referenced on the title page required the Department to convene a stakeholders group to consider incentives for nursing facilities either to close completely or to reduce their number of licensed beds. The Department met twice with the group, which considered a variety of information from available sources. The group's consensus was that at present such incentives should not be pursued, and the Department should not begin a formal rulemaking procedure on the subject. The group will continue to meet to discuss potential changes to the long term care system, including the possibility of such a facility / bed elimination program.

Summary of Action by the Department

The statute referenced on the title page was in part titled "An Act Relating to reshaping the delivery of long-term care services;…" As one possible part of that reshaping, the Legislature considered a program for the elimination of licensed nursing facility beds and the closure of entire nursing facilities. Section 8 of the act gave this directive:

> *The department of social and health services shall convene a work group of stakeholders to discuss and identify one or more mechanisms to incentivize nursing facilities to close or to eliminate licensed beds from active service. The department shall adopt rules to implement the recommendations of the work group. By September 1, 2011, the department shall report to the governor and the legislature on the recommendations of the work group and the status of the department's rule-making efforts and any statutory impediments to the implementation of any of the recommendations*.

The task of complying with this mandate was given to the Office of Rates Management (ORM) within the Aging and Disability Services Administration (ADSA). The ORM includes the section that sets Medicaid rates paid to nursing facilities under Ch. 74.46 RCW.

The ORM convened a workgroup of stakeholders interested in nursing facilities. The workgroup met on August 9 and 23, 2011. Those attending one or both meetings were:

Amber D. Lewis	Providence Health Care
Charlene Boyd	Providence Health Care
Vicki Christopherson	Providence Health Care
Deb Murphy	Aging Services of Washington
Paul Montgomery	Aging Services of Washington
Scott Sigmon	Aging Services of Washington
Rich Miller	Washington Health Care Association
Lauri St. Ours	Washington Health Care Association
Gwynn Rucker	Chair, Washington Health Care Association
Nick Federici	Lobbyist, Health Care Issues
Sahar Banijamali	Service Employees International Union
Carma Matti-Jackson	Senior Fiscal Analyst, House Ways and Means, Health and Human Services Subcommittee
MaryAnne Lindeblad	Assistant Secretary, Aging and Disability Services Administration
Ken Callaghan	Office of Rates Management, Aging and Disability Services Administration
Ed Southon	Office of Rates Management, Aging and Disability Services Administration
Irene Owens	Residential Care Services Division, Aging and Disability Services Administration
Marj Ray	Residential Care Services Division, Aging and Disability Services Administration
Lisa Yanagida	Residential Care Services, Aging and Disability Services Administration
Terry Marker	Home and Community Services Division, Aging and Disability Services Administration
Liz Prince	Home and Community Services Division, Aging and Disability Services Administration
Debbie Blackner	Home and Community Services Division, Aging and Disability Services Administration
Janis Sigman	Certificate of Need Section, Department of Health
Kendra Pitzler	Department of Health
Barbara Runyon	Department of Health
Edd Giger	Central Budget, Department of Social and Health Services Administration

The first thing the working group did was to put its mandate in the larger context of the law. Section 1 of c. 366 is effectively a purpose or intent section, and says:

> *The legislature has a long history of supporting seniors where they live whether it is at home or in a licensed care facility. It is widely recognized that the consumer of senior services and long-term care of tomorrow will have different demands and expectations for the type and manner of supportive and health care services that they receive. Cost efficiencies must and can be achieved within the health care system. Through the use of care coaches, technology-supported health and wellness programs, and by allowing greater flexibility for the specialization and use of nursing facility beds, costly hospitalizations and rehospitalizations can be reduced and the entry to licensed care settings can be delayed (emphasis added).*

The group felt that its mandate needed to be understood in light of the intent stated in Section 1. Rather than considering bed and facility elimination in isolation, the group felt that it needed to be considered in the broader context of re-envisioning the entire range of long-term care services to older and disabled persons.

The group looked at information on a variety of subjects, for example:

- Hospital Discharge Data – 2009 and 2010 information on the destination of persons discharged from hospitals – e.g., home, home health, skilled nursing facility – arranged by hospital and by age groups.
- Licensed bed capacity of facilities by license type
- In-home providers by county.
- Department of Health (DOH) nursing Home bed projections.
- DOH certificate of need nursing home bed supply log.
- Adult family homes licensed beds occupied by Medicaid clients.
- Boarding home licensed beds occupied by Medicaid clients.
- Licensed facilities and beds by county.
- June 2011 long-term care forecast summary by fiscal year.

Discussion at the meetings included the following questions:

- Is this the right time to consider bed and facility elimination?

- What are the purposes and goals of a bed and facility elimination program?

- Would such a program be purely voluntary on the part of facility operators? If so, would any operator wishing to eliminate beds or close a facility be able to do so, or would there be limits on who could participate? If there were limits, what would be the standards for deciding on who could participate, and who would decide and apply them?

- What part would the program play in the re-envisioning of long term health care services for the elderly and disabled? What is the context in which the subject of bed and facility elimination is being considered?

- Do recent changes to the Medicaid rate methodology have a bearing on the necessity for such a program? Have the elimination of bed-banking as a factor in rates, and the increase in minimum occupancy assumptions in several rate components been sufficient incentives to reduce the number of licensed beds?

- Is there a need for better information on capacity and access to care, for all care settings throughout the state? How can such information be acquired? Should all providers be required to respond to surveys from their licensing or paying agencies?

- Do we have good information on how residents move sequentially through the various care settings available to them? If not, how can it be acquired?

- What are the types and levels of care that nursing facilities should be delivering? Are facilities delivering that now?

- What kinds of incentives could be offered to promote facility closure and bed elimination? Are there any non-financial incentives that could be offered – for example, easier conversion of the beds or space to other care settings, or allowing one administrator to supervise multiple care settings? Would state licensing or health care laws, or federal health care laws impose any limits on such possible non-financial incentives?

- How would financial incentives be structured? On a per-bed basis, or otherwise? Would payments be uniform for all facilities across the state? If not, how would they vary? What kinds of commitments for the future would be expected from participants – e.g., pledges not to replace the beds/facilities?

- Is funding for financial incentives likely to be available in the foreseeable future? At what levels? From what sources?

- Would the program be expected to show a net financial gain for the state – that is, to save more money than it cost? How would that be measured? Is it possible? If all residents who need the services of a nursing facility would continue to get them, what would be the savings? Would higher occupancy levels at the remaining facilities result in sufficient economies to pay for the program? How could such economies be measured and captured?

- How would bed/facility elimination be integrated with the existing Certificate of Need program? Would it ever make sense to allow the addition of new beds/facilities in a service area where the state had recently paid for the elimination of beds/facilities?

- What has been the experience of other states, such as Minnesota that have tried such programs?

- Should expansion of the activities permitted under a nursing facility's license be considered as part of the re-envisioning of long term care services? How would such expansion relate to bed and facility elimination?

After the second meeting, the consensus of the workgroup was as follows:

1. The group wholeheartedly supports the statement of legislative intent found in Section 1 of c. 366. Population factors, consumer expectations, and funding realities will continue to drive the need for changes in the delivery of long term care services. Providing high quality care in more efficient and creative ways is a necessity.

2. A nursing facility is one of the more expensive long-term care settings. Therefore, it is not surprising that an effort should be made to reduce the number of residents in nursing facilities. Consideration of a program to incentivize the closure of entire nursing facilities, along with the elimination of licensed beds at facilities that would remain open, is one possible aspect of that effort.

3. While efficiency and economy are valid concerns, so are quality of care and sufficient access to care. The state should not routinely have a significant surplus of nursing homes or nursing home beds – even while opinions can differ as to how a surplus might be defined. At the same time, any resident that truly needs placement in a nursing facility should generally be able to find a bed in a reasonably located, well run facility providing good quality care.

4. Operators of nursing facilities are genuinely open to the idea of re-examining how they function, the type of services they provide, and how they relate to other care settings. However, such re-examination makes the most sense when done in the context of the entire system of long-term care.

5. Budget realities for the present, and for the foreseeable future, would appear to make it unlikely that a public source of funding for a bed and facility elimination program would be readily found. It is at least questionable that an elimination program could reliably identify sufficient savings to pay entirely for itself.

Recommendation

Based on the foregoing conclusions, the consensus of the workgroup was to ask the Department not to initiate a formal rule-making procedure on a bed and facility elimination program at this time. A bed and facility elimination program raises many difficult practical, financial, and legal questions. Given the very short time the workgroup had to discuss the matter and formulate its views, it does not believe that it would be appropriate for the Department to file a CR- 101 and begin formal rule-making at present.

However, the work group very much wants to continue to meet, to discuss the re-envisioning of the long term care system, and to consider what feasible, incremental improvements can be made to the system. As its next step, the work group will meet again in September, and will invite representatives of home and community service providers.